

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
HC 2 South, 280 State Drive
Waterbury, VT 05671-2060
http://www.dail.vermont.gov
Survey and Certification Voice/TTY (802) 241-0480
Survey and Certification Fax (802) 241-0343
Survey and Certification Reporting Line: (888) 700-5330
To Report Adult Abuse: (800) 564-1612

October 24, 2017

Ms. Angela Pelletier, Manager Spring Village At Essex 6 Freeman Woods Essex, VT 05451

Dear Ms. Pelletier:

Enclosed is a copy of your acceptable plans of correction for the survey conducted on September 21, 2017. Please post this document in a prominent place in your facility.

We may follow-up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN Licensing Chief

amlaMCotaPN



Reviolation

PRINTED: 10/09/2017 FORM APPROVED

Division of Licensing and Protection (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING С B. WING 09/21/2017 0653 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **6 FREEMAN WOODS** SPRING VILLAGE AT ESSEX **ESSEX, VT 05451** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) R100 R100: Initial Comments: Please see attached plans of An unannounced investigation of two complaints was conducted by the Division of Licensing & Correction. Protection on 9/19-21/2017. The following regulatory deficiencies were identified as a result of the investigation: R126 V. RESIDENT CARE AND HOME SERVICES R126 SS=E 5.5 General Care 5.5.a Upon a resident's admission to a residential care home, necessary services shall be provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to assure that necessary services are provided or arranged to meet the resident's personal, psychosocial, nursing and medical care needs. Findings include: Per staff interview with the Director of Nursing Services, during the night shift on 9/20-21/17 at approximately Midnight, staff called him/her at home due to a resident with escalating aggressive behaviors. During the incident Resident #1 was noted by a caregiver coming out of his/her room. As s/he proceeded toward the staff member she was "screaming" and started taking pictures off the wall. EMT (Emergency Medical Technician) and the Police were called to the scene as staff could not contain the situation. During the incident it is suspected (though not Division of Licensing and Protection LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

RIALD-RITY POC'S accepted 10/24/17 mt/gineral/mc

STATE FORM

Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_  $\cap$ B WING 0653 09/21/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **6 FREEMAN WOODS** SPRING VILLAGE AT ESSEX ESSEX, VT 05451 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY** R126 Continued From page 1 R126 witnessed) that R#1 pulled one resident (R#2) out of bed while staff were doing rounds. It is also noted that s/he also entered the room of R#3, while staff were speaking with responders, and sat on the bed (also sitting on the resident). During the visit it is reported that staff stated to Emergency Responders that the staff felt unprepared to deal with the situation and unsupported by management. Emergency Responders note that it is not the first time they have been called to the facility to assist with resident behaviors. It was also noted that during the incident staff were engaged in trying to contain R#1 and protect other residents which precluded them having the ability to check other residents, do 15 minute safety checks, and perform other job duties. Per interviews on 9/22/17, the staff present during the incident above confirmed that staffing numbers precluded them from doing every 15 minute checks and other duties when a resident became agitated or needed additional monitoring. They stated that this does happen on the night shift on occasion and that it then takes away from other care provision. Additionally, per record review and interview, the facility should have been aware for the need for increased supervision for this resident, as R#1 had escalating behaviors on 9/17/17 and at that time s/he struck R#4 on the back while walking behind him/her. The incident seemed to have happened without provocation. 2. On 9/19/17 during a dinner observation in the Junction dining room, Residents were moved into the room starting at 4:35 PM. At 5 PM, residents were still being moved into the dining room and a staff member began serving water. The staff

STATEMEN	Of Licensing and Pro NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	SURVEY
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		0653	B. WING		09/2	21/2017
NAME OF	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
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SPRING	VILLAGE AT ESSEX	ESSEX, V	T 05451			
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R126	Continued From pa	ge 2	R126			
	carrying dinner plat serving residents. If room was unattend while food was in plates and returned severatime the second stadinner, leaving the idinner plates. Two idining room with the member got up and cut their salad into it stated when asked, prevents them from checks and other as stated that they have shifts or stay late be Of note, staff are reduring the survey prearful of retaliation.  4. In a review of oth have responded to especially on the evassistance with resiresidents exiting the	es into the kitchen to begin es into the dining room and ouring this time, the dining ed by staff on 3 occasions ace. During this time, one walked away from the table. A to find that resident and guide the room. Several minutes add to use the bathroom and isted him/her to the bathroom all minutes later. During this aff member was serving froom frequently to obtain family members were in the eir spouses and one family assisted several residents to more manageable pieces.  If visit 9 anonymous staff reviewed and of these, 7 staff that the current staffing doing every 15 minute spects of their job. They also be been asked to work extra ecause of inadequate staffing. Inctant to answer questions rocess because they are the documents, local Police multiple calls from facility staff, the ining and night shifts, for dent behaviors and with a facility. In one instance a several miles away at a busy				
R132: SS=E		E AND HOME SERVICES	R132			

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DIVISION	of Licensing and Pro	nection			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING.		COMPLETED
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		0653			09/21/2017
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	:			DEFICIENCY)	
D433	Continued From no	a. 2	R132		
R132	Continued From pa	ge 3	1/132		
	5.5 Special Care U	nits			:
	•				
	5.6,c A home that	has received approval to			ì
		are unit must comply with the			
		ained in the request for			<u>;</u>
		e will be surveyed to			
		ecial care unit is providing the			,
		aining and physical			į
		as outlined in the request for			
	approval.	•			
			:		
	This REQUIREMEN	NT is not met as evidenced			
	by:				
		view and staff interviews the	1		;
		ure that the Special Care Unit			
		the services, staffing, and			
		tlined in the request for	i		
		re building is categorized as a		•	
	SCU. Findings incl				
	J				;
	In the request for a	pproval to operate the SCU,		·	
		at the services would provide			
•		ents with Dementia in the			
		ironment while keeping the	:		
		review of facility incidents,			
		alking behind Resident #4 on		,	:
		that resident on the back,			
:		alerted the facility that			·
		on is necessary to protect			
1	other residents. On	9/20/17 it is suspected that			
	Resident#1 pulled	Resident #2 from bed to the			
		med that R#1 entered the			
	room of R#3 that sa	ame night, who was lying in			
		n/her. Resident #3 is on every			
		ecks and during both the last			
		3/30/17 and this investigation,			
		being consistently conducted.			
		-			
	In staff interviews 7	of 9 staff interviewed stated			

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		0653	B. WING			1/2017
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
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R132	Continued From pa	ge 4	R132			A page was a sure
	unable to conduct the complete all their jo	ng "short staffed" they are he safety checks and cannot b duties.  documents, local Police have			·	
	responded to calls the evening and nig resident behaviors a facility. In one instal	from facility staff, especially on the shifts, for assistance with and with residents exiting the note a resident was found at a busy intersection			,	an regarding and the contract of the contract
	during an investigat despite this citation	d for insufficient staffing ion completed on 8/30/17 and the facility has continued to and has lost several abers.				MR MICH CARD AND STREET, IN ARREST OF MR MICHAEL CARD.
	Manager stated tha regarding the initial new staff, because be found. There are completion of the true by Emergency Responder of the true of true of the true of true of the t	/19/17, the Memory Care t there is no information Dementia training given to all his/her training book cannot also no documents of aining available. In interviews conders on the night of informed that staff did not out escalation of behaviors and dents with Dementia.				
R141 SS=E	V. RESIDENT CAR	E AND HOME SERVICES	R141			e compression de la compressio
	5.9 Level of Care a	nd Nursing Services				1
	overview or medica retained in a resider	to require more than nursing tion management shall not be ntial care home unless the lowing subsections (I)-(5) are				

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		0653	B. WING		09/21/2017	
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NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST	TATE, ZIP CODE		
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R141	Continued From pa	ge 5	R141			
		rvices required are either: than three times per week; or	conservable to the account			
	more than 60 days improving during the service provided is	o to seven days a week for no and the resident's condition is at time and the nursing limited in nature; or Medicare-certified Hospice	The second secon			
	a written agreemen home health agenc nursing services ar	a registered nurse on staff, or it with a registered nurse or y, to provide the necessary id to delegate related care to qualified staff; and	en e			
		ole to meet the resident's acting from services to other	and the state of t			
	prospective resider admission, which e home provides or a and under what circ	a written policy, explained to its before or at the time of xplains what nursing care the irranges for, how it is paid for cumstances the resident will e to another level of care; and	Andreas (Andreas Andreas Andre			
	informed of their op in the residential ca This REQUIREMEN by: Based on observati interviews the facili home is able to me	ving such care are fully oftions and agree to such care are home.  NT is not met as evidenced on, documentation, and staff by failed to assure that the et the resident's needs without vices to other residents.				
		w with the Director of Nursing	end the comment is the control of th	•		

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R141	: Continued From pa	ge 6	R141				
	home due to a resident aggressive behavior Resident #1 was no of his/her room. As staff member she was taff member as taff of bed while staff was to have bed (also During the visit it is Emergency Resport unprepared to deal unsupported by ma Responders note thave been called to resident behaviors, the incident staff was contain R#1 and proprecluded them have residents, do 15 mit perform other job designed.	rs. During the incident ofted by a caregiver coming out s/he proceeded toward the vas "screaming" and started he wall. EMT (Emergency) and the Police were called to could not contain the situation. It is suspected (though not pulled one resident (R#2) out ere doing rounds. It is also entered the room of R#3, eaking with responders, and o sitting on the resident), reported that staff stated to oders that the staff felt with the situation and nagement. Emergency that it is not the first time they of the facility to assist with It was also noted that during ere engaged in trying to otect other residents which ving the ability to check other nute safety checks, and					
	They stated that thi shift on occasion are other care provision Additionally, per reclacility should have	needed additional monitoring, sides happen on the night and that it then takes away from a. cord review and interview, the been aware for the need for on for this resident, as R#1	Paramentolisha basada da managara da da managara da managara da managara da managara da managara da managara d				

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R141   Continued From pa	ige 7	R141			
had escalating beh	aviors on 9/17/17 and at that			•	
	4 on the back while walking				
behind him/her. The	e incident seemed to have				
j happened without μ	provocation.				
	ng a dinner observation in the				
	m, Residents were moved into	(		:	
	t 4:35 PM. At 5 PM, residents				
	ved into the dining room and a				
	n serving water. The staff				1
	go into the kitchen to begin				
	es into the dining room and				
	Ouring this time, the dining			İ	
	ed by staff on 3 occasions lace. During this time, one				
	walked away from the table. A				
	to find that resident and guide	A CONTRACTOR OF THE CONTRACTOR			
	ne room. Several minutes				
	eded to use the bathroom and			•	
	isted him/her to the bathroom				
	al minutes later. During this			:	
	aff member was serving				
dinner, leaving the	room frequently to obtain			:	
	family members were in the				
	eir spouses and one family				
	assisted several residents to				
cut their salad into	more manageable pieces.				
2. Design the group of	unická o zaoumenia steff				
	y visit 9 anonymous staff rviewed and of these, 7 staff				
	that the current staffing	***************************************			
	doing every 15 minute	n and a second			
	spects of their job. They also	Account			
	ve been asked to work extra				
	ecause of inadequate staffing.				
	ed for insufficient staffing	9			
	tion completed on 8/30/17 and				l
	, the facility has continued to				ſ
admit new resident	s and has lost several				ļ
additional staff mer	nbers. Of note, staff are				

Division	of Licensing and Pro	otection				
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		questions during the survey	90		•	
	process because the	ney are fearful of retaliation.	A A de la			
	4. In a review of ot	her documents, local Police	60	•		
		multiple calls from facility staff,	en e			
		vening and night shifts, for				W. T.
		ident behaviors and with e facility. In one instance a				
	resident was found	several miles away at a busy				A Capacitan Co.
	intersection.		and the same of th			account of the contract of the
	Vancana					
R146 SS=E	V. RESIDENT CAR	RE AND HOME SERVICES	R146			en considera
اسا حـــٰ						NG46040.00.
	5.9.c (3)				,	
	: 	and aurominion to all dispot				
		and supervision to all direct arding each resident's health				
		tritional needs and delegate	5000			ndhopmenase.
	nursing tasks as ap					
	This DEOLUDEME	NT is not met as evidenced			ŕ	A. A. 400ddana
	by:	N Is not met as evidenced				ACCEPTANCE OF THE PROPERTY OF
	Based on staff inter	rviews the facility failed to				A number of A
		gistered Nurse provides				After a de care de la
		ervision to all direct care g each resident's health care				
	needs, Findings inc					
			:			*
		21/17, the facility Memory Care	:			1
		ed Nursing Assistant (LNA) nentia training, is responsible				:
		ining to the caregiver staff.				
	S/he does all the or	rientation and Dementia				
		os and is also the supervisor				
		iff. In an interview on 9/21/17, stered Nurse/Director of		Lander		
		confirmed that s/he does not				
		aff training and does not				:

Division	of Licensing and Pro	tection			·····	
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NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE ZIP CODE		
NAME OF F	PROVIDEN OR SOFFEILE		AN WOODS	, A.C., 21, CODE		
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R146	Continued From pa	ge 9	R146			
	supervise the direct	care staff.	An announcement			
R150 <b>S</b> S=E	V. RESIDENT CAR	E AND HOME SERVICES	R150			T P P P P P P P P P P P P P P P P P P P
	5.9.c (7)		MANUFACTURE CAPPER CAPP	*		
: : : :		ms or signs of illness or ed at the time of occurrence, ken;				** 17.500 V 1985 V 1985 V 1885
ا لا پ	by:	NT is not met as evidenced	anaxvenenter veri			
n O new y rear work with resolution that the	facility failed to assu accident are record	view and staff interviews, the ure that that signs of an ed at the time of occurrence, ken. Findings include:				A TOTAL STATE OF THE PROPERTY
MARROALIZEREE PER PER PER MARROE MARROE AND ALL CALLEGORS	resident's behavior incident, during white were called. The inchours of 9/20/17 and residents (R#2 & Rivequested the specimorning of 9/21/17, provide all the facts	an incident occurred when a escalated into an aggressive ch Emergency Responders cident took place in the early d included R#1 and two other #3). When the surveyor fics of the incident, the the DNS was unable to of the incident. There was no	To the state of th			A AdditAN planeye meranenmentendrakidiANXIII - 1, e. e. e. e. e. e. e. e.
	report containing ver facility was requested reports from the car responded to the fa	lable other than one incident ery little information and the ed to provide the incident re staff and Manager, who cility at the time, via e-mail. mentation has been provided ncy as of 10/5/17.				;
R178 S <b>S</b> =E	V. RESIDENT CAR	E AND HOME SERVICES	R178			
	5.11 Staff Services		allegack commenses			

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	Division	of Licensing and Pro	tection				
-		T DF DEFICIENCIES OF CDRRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION		SURVEY PLETED
	,		0653	8 WING			C <b>21/2017</b>
	NAME OF E	ROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
	NAME OF F	RONDEN ON SOFFLICK		AN WOODS	TATE, ZIT GODE		
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	R178	Continued From pa	ge 10	R178			
		qualified personnel provide necessary of healthy environment appropriate action in or other emergencie. This REQUIREMENT by: Based on record refacility failed to assumber of qualified times to provide necessafe and healthy emprompt, appropriate illness, fire or other include:  1. Per staff intervier Services, during the approximately Midn home due to a reside aggressive behavior Resident #1 was not of his/her room. As staff member she we taking pictures off the Medical Technician the scene as staff or During the incident in witnessed) that R#1 of bed while staff were spessat on the bed (also During the visit it is in Emergency Responding unsupported by mar	views and staff interviews the ure there was a sufficient personnel available at all cessary care, to maintain a vironment, and to assure action in cases of injury, emergencies. Findings  w with the Director of Nursing and the shift on 9/20-21/17 at ight, staff called him/her at				10.000 Control of the

Division of Licensing and Protection STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_  $\cap$ B WING 09/21/2017 0653 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 6 FREEMAN WOODS SPRING VILLAGE AT ESSEX ESSEX, VT 05451 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) R178 R178 : Continued From page 11 have been called to the facility to assist with resident behaviors. It was also noted that during the incident staff were engaged in trying to contain R#1 and protect other residents which precluded them having the ability to check other residents, do 15 minute safety checks, and perform other job duties. Per interviews on 9/22/17, the staff present during the incident above confirmed that staffing numbers precluded them from doing every 15 minute checks and other duties when a resident became agitated or needed additional monitoring. They stated that this does happen on the night shift on occasion and that it then takes away from other care provision. Additionally, per record review and interview, the facility should have been aware for the need for increased supervision for this resident, as R#1 had escalating behaviors on 9/17/17 and at that time s/he struck R#4 on the back while walking behind him/her. The incident seemed to have happened without provocation. 2. On 9/19/17 during a dinner observation in the Junction dining room, Residents were moved into the room starting at 4:35 PM. At 5 PM, residents were still being moved into the dining room and a staff member began serving water. The staff member then left to go into the kitchen to begin carrying dinner plates into the dining room and serving residents. During this time, the dining room was unattended by staff on 3 occasions while food was in place. During this time, one resident got up and walked away from the table. A staff member went to find that resident and guide him/her back into the room. Several minutes later, a resident needed to use the bathroom and a staff member assisted him/her to the bathroom

DIVISION OF LICENSING AND PE		(Y2) MULTIPLE	CONSTRUCTION	/Y2\ DATE CHOVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	0052	B WING		C
	0653			09/21/2017
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SI KING VIELAGE AI LOSEA	ESSEX, \	/T 05451		
(7.7)	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
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			DEFICIENCY)	
R178   Continued From pa	age 12	R178		
·	-			
	ral minutes later. During this aff member was serving			
	room frequently to obtain	•		
	family members were in the	. 1		
	eir spouses and one family			:
	d assisted several residents to	1		
	more manageable pieces.			
:	•	ĺ		ŧ
	y visit 9 anonymous staff	i .		
	erviewed and of these, 7 staff			
	, that the current staffing			
	n doing every 15 minute			
	spects of their job. They also			
	ve been asked to work extra			
	ecause of inadequate staffing.			
	ed for insufficient staffing			
	tion completed on 8/30/17 and the facility has continued to	-		
	s and has lost several	]		
	nbers. Of note, staff are	}		
	questions during the survey	!		
	ney are fearful of retaliation.			; ;
	,			i r
4. In a review of ot	her documents, local Police			<b>,</b>
	multiple calls from facility staff,			•
	vening and night shifts, for			
	ident behaviors and with	1		
	e facility. In one instance a	:		
	several miles away at a busy			
intersection.		:		
R179 V RESIDENT CAR	RE AND HOME SERVICES	R179		
SS=E	CE AND FIGHE OF WARDED	1,11,0		
,		<b>Vocations</b>		
5.11 Staff Services		a de constante de		
5.11,b. The home n	nust ensure that staff	and the second		
	etency in the skills and			
	e expected to perform before			

Division	of Licensing and Pro	tection				
	NT OF DEFICIENCIES LOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPLI	
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	610000000000000000000000000000000000000			CROWDENG PLAN OF CORDECT	- L	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  GC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE.	(X5) COMPLETE DATE '
R179	Continued From pa	ge 13	R179			
	shall be at least twe year for each staff p	care to residents. There lve (12) hours of training each person providing direct care to ling must include, but is not ling:		•	continue order.	
	(3) Resident emerg such as the Heimlic or ambulance conta (4) Policies and pro- reports of abuse, no (5) Respectful and residents; (6) Infection contro- limited to, handwash maintaining clean en- pathogens and univ	emergency evacuation; lency response procedures, h maneuver, accidents, police	•		es - A de como como más de desente disperis de Carlos de Carlos de mercanos (mos especialmente como cinco acer	
Tr. ACT ALIGN	by: Based on document facility failed to assu competency in the sexpected to perform care to residents. F  Per staff interview w Services, during the approximately Midnihome due to a resid aggressive behavior Resident #1 was no of his/her room. As staff member she w	ith the Director of Nursing night shift on 9/20-21/17 at ght, staff called him/her at				

Division of Licensing and Protection

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Division	of Licensing and Pro	otection				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
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		0050	B. WING		0013	
		0653	0.11110		1 09/2	1/2017
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	CLIMMADV STA	TEMENT OF DEFICIENCIES	***************************************	PROVIDER'S PLAN OF CORRECT	ION	/VE)
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R179	Continued From pa	ge 14	R179			
	·		dellower			
		) and the Police were called to $\hat{\cdot}$	·			
		could not contain the situation.	- Control			
		it is suspected (though not	AAA-cenii			
		I pulled one resident (R#2) out	***************************************			
		ere doing rounds. It is also				
		entered the room of R#3,				
	while staff were spe	eaking with responders, and	Veneza			
	sat on the bed (also	sitting on the resident).	- Inches			
		reported that staff stated to	-			
	Emergency Respor	iders that the staff felt		•		
		with the situation and				
	unsupported by ma	nagement. Emergency	Arrabia			
	Responders note th	at it is not the first time they				
	have been called to	the facility to assist with				
	resident behaviors.	An Emergency Responder				
	stated that staff app	peared to be "at a loss" how to			•	
	respond to the esca	lating behaviors.				
		_				
	Per interview on 9/2	21/17 the facility Memory Care				
	Manager, a License	ed Nursing Assistant (LNA)				
		entia training, is responsible				
Ì	for providing all train	ning to the caregiver staff.				2
	S/he does all the or	ientation and Dementia	•			
	training using video	s and is also the supervisor			*	
		ff. This training is provided in a	Acceptance of the contract of			
	classroom setting a	nd by observation of care	Kamanasa			
		mory Care manager and other				
;		n interview on 9/21/17 the	-			:
3		that s/he does not do the				•
		ing and does not supervise	dakenajoj			
	the direct care staff.	•	decompanies.			
			Manager Asia	•		-
			m Adoption			
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			un dij tyket y			
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			grappers			

## 10/13/17

Ms. Pamela M. Cota, RN
Licensing Chief
Vermont Agency of Human Services
Department of Disabilities, Agency and Independent Living
Division of Licensing and Protection
HC2 South, 280 State Drive
Waterbury, VT 05671-2060

Dear Ms. Cota,

In response to the letter received dated October 9, 2017 regarding the complaint investigation that was completed by the Division of Licensing and Protection on September 21, 2017, I respectfully submit our Plan of Correction.

#### R126 SS=E

- 1) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be retrained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Complete 10/15 +17/2017
- 2) In speaking with Captain Rick Gary at the Essex Police Department he stated he had no concerns with our community. It is a community on Carmichael St. where they are "inodiated with calls and have to respond because they get no response when they call back."
- 3) The acting ED had a discussion with the DON regarding the importance of addressing resident behaviors immediately. The DON will address this with all nurses and med techs in a meeting on October 20, 2017. Since this incident the resident was hospitalized and medications were changed. The resident's care plan was updated since her return from the hospital. The ED will audit the charts weekly to insure the care plans and assessments are completed in a timely manner. Any issues identified will be

addressed with the staff person involved immediately. Audits will be reviewed weekly at the Quality Assurance meeting scheduled for Thursdays at 1:00pm. Omplete

4) The Food Service Director and dietary team will ensure that all foods will be cut appropriately for residents coming straight from the kitchen.

5) There is a new procedure in place for the dining room. One staff member will remain in the dining room at all times while the others provide the food or attend to other needs of the residents. This was in-serviced on 9/27/17. Complete 9/27/17

### R132 SS=E

- 1) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be retrained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Complete 10/15+17/2017
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4) Two agencies were contracted to assist the community in their staffing needs as of September 25, 2017. Agency will stay in place until the community has hired all staff necessary to meet the needs of the residents of a special care unit. The supervisor will review staffing levels daily and adjust accordingly to ensure appropriate staffing to

- accommodate the needs of the residents in the Community. Results of the daily review will be reported at the Quality Assurance Meeting.
- Since the complaint investigation a document was found dated 8/28/17 that indicates who has had dementia training. The three staff members on the night of the incident with resident #1 were listed on this document. However, all three will attend a retraining on October 15 and/or 17, 2017 with an emphasis on behaviors. The supervisor will review all behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. (Domplete 10/15 417/2017)

#### R141 SS=E

- The community has a full time DON that is a licensed RN on staff as of September 2017.
   She is responsible for assessing and determining if the community can meet the needs of the resident prior to admission as well as once an established resident of the community.
- 2) The resident agreement provides information regarding the care the community provides as well as how a third-party vendor payment would be paid for. It also includes why a transfer based on care needs would be handled.
- 3) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be retrained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Complete 10/15 + 17/2017
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- 6) The Food Service Director and dietary team will ensure that all foods will be cut appropriately for residents coming straight from the kitchen.
- 7) There is a new procedure in place for the dining room. One staff member will remain in the dining room at all times while the others provide the food or attend to other needs of the residents. This was in-serviced on 9/27/17. Complete 9/27/17

R146 SS=E

1) The RN/DNS is responsible for the care plans of the residents. The Memory Care Director takes the information of the care plans and inputs it into an assignment sheet the care providers use to care for the residents on a daily basis. The RN/DNS is involved in all care aspects of the residents as well as clinical. If there are any concerns or issues they are discussed with the RN/DNS for direction or updates in the care plans. The Memory Care Director trains all staff in dementia using her previous training, videos and several documents specific to dementia.

R150 SS=E

1) The information requested was faxed on 9/22/17 and sent a second time on 10/5/17 via email from the Director of Operations when requested by the surveyor who conducted the investigation. In the future, information at the time of the survey or investigation will be provided in a timely manner. This has been reviewed with the RN/DNS.

Complete 9/22/17 + 19/5/17

R178 SS=E

1) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or

other job duties. The staff in question were trained in dementia however will be retrained with an emphasis on behaviors on October 15 and/or 17, 2017.

- 2) In speaking with Captain Rick Gary at the Essex Police Department he stated he had no concerns with our community. It is a community on Carmichael St. where they are "inodiated with calls and have to respond because they get no response when they call back."
- 3) The acting ED had a discussion with the DON regarding the importance of addressing resident behaviors immediately. The DON will address this with all nurses and med techs in a meeting on October 20, 2017. Since this incident the resident was hospitalized and medications were changed. The resident's care plan was updated since her return from the hospital. The ED will audit the charts weekly to insure the care plans and assessments are completed in a timely manner. Any issues identified will be addressed with the staff person involved immediately. Audits will be reviewed weekly at the Quality Assurance meeting scheduled for Thursdays at 1:00pm. Complete 10/20/17
- 4) The Food Service Director and dietary team will ensure that all foods will be cut appropriately for residents coming straight from the kitchen.
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- 7) Two agencies were contracted to assist the community in their staffing needs as of September 25, 2017. Agency will stay in place until the community has hired all staff necessary to meet the needs of the residents of a special care unit. The supervisor will review staffing levels daily and adjust accordingly to ensure appropriate staffing to accommodate the needs of the residents in the Community. Results of the daily review will be reported at the Quality Assurance Meeting.

# R179 SS=E

1) The community opened in November 2016. All staff upon orientation prior to starting their schedule hired for are required to do the 12-hour training requirements. The

community has conducted in house monthly trainings since opening and will continue to do so going forward.

- 2) SVE has changed the policy for overnight staff. One caregiver will work with a resident that has any behavior concerns so the others can continue to do the safety checks or other job duties. The staff in question were trained in dementia however will be retrained with an emphasis on behaviors on October 15 and/or 17, 2017. The supervisor will review All behavioral interventions with the care staff as they are added to the care plan. The supervisor will observe staff to ensure that behavioral interventions are implemented as addressed in the care plan. Any issues identified will be addressed with the individual involved for re-training. Retraining methods will include role play, return demonstration and discussion. Results of intervention observation will be reviewed at the Quality Assurance Meeting. Completo
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- 5) The RN/DNS is responsible for the care plans of the residents. The Memory Care Director takes the information of the care plans and inputs it into an assignment sheet the care providers use to care for the residents on a daily basis. The RN/DNS is involved in all care aspects of the residents as well as clinical. If there are any concerns or issues they are discussed with the RN/DNS for direction or updates in the care plans. The Memory Care Director trains all staff in dementia using her previous training, videos and several documents specific to dementia.
- All the above has been added to the QA checklist that the DOO will be reviewing weekly
  until the Executive Director is replaced. DOO will do monthly QA visits to ensure the
  community is in compliance with the POC.

Respectfully Submitted,

Angela Pelletier – Acting Executive Director – SVE/Director of Operations – WSL

10/24/17-resent with updates